DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **12-16**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **September 1, 2012**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 09/01/12-09/30/12 $0** * **b. FFY 10/01/12-09/30/13 $3,171,052** **
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 3.1-A: Pages 2, 7, 8a, 10(a), 12** **Attachment 3.1-A Supplement: Pages 2, 2.1, 3(c), 3(c)(iii), 4(a)** **Attachment 3.1-B: Pages 2a, 6, 7, 10(a), 11** **Attachment 3.1-B Supplement: Pages 2, 2.1, 3(c), 3(c)(iii), 4(a)** **Attachment 4.19-B: Pages 1, 1(a), 2(x)** ****SEE REMARKS BELOW**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 3.1-A: Pages 2, 7, 8a, 10(a)** **Attachment 3.1-A Supplement: Pages 2, 3(c), 3(c)(iii)** **Attachment 3.1-B: Pages 2a, 6, 7** **Attachment 3.1-B Supplement: Pages 2, 3(c), 3(c)(iii)** **Attachment 4.19-B: Pages 1, 1(a)**

10. SUBJECT OF AMENDMENT:
Lactation Counseling
(FMAP = 50%)

*Given the provision will not be implemented until approval is received, for the period 9/1/12-9/30/12, there is no fiscal impact.
**Reflects an 11-month impact (11/1/12-9/30/13).
NOTE: Implementation of this provision will not occur until the first day of the month following 30 days after SPA approval.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Oper & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: October 23, 2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **December 28, 2012**
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: **September 01, 2012**	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: **Ricardo Holligan**	22. TITLE: **Acting Associate Regional Administrator** **Division of Medicaid and State Operations**

23. REMARKS:

*****This SPA proposes to reimburse Article 28 Clinics and private practioners for lactation counseling services for pregnant and postpartum women when such services are ordered by a licensed physician, registered physician assistant, registered nurse practioners, or licensed midwife and provided by a certified lactation consultant, determined by the Commissioner of Health.***